Message From State Controller
Kathleen Connell

In this edition of the *Controller's Quarterly*, we focus on the current state of health care in California, a $63 billion business sector with over 920,000 workers. Health care policy is important for the continued economic growth of California not only as a key industry, but also as a component in all industry's need to have healthy and productive workers. However, our current health care system is in a state of crisis as the uninsured ranks rise, the quality of health care falls and the baby boom generation ages.

We begin this edition by examining the current status of the 7.3 million uninsured Californians, or one-fourth of the non-elderly population. We analyze the types of health care coverage, and demographically break down the uninsured by age and ethnicity. The surprising conclusion is that the percentage of uninsured Californians has continued to grow even though the economy has expanded.

Another area of increased importance is the quality of health care delivered by HMOs, independent medical groups and other medical providers. We are pleased to incorporate two renowned guest authors' perspectives on this very subject. Startlingly, they both find that quality of care errors account for thousands of preventable deaths each year.

In order to address the issue of declining health care quality, we decided to profile two innovative and leading health care providers. Both are concerned with increasing the quality of health care provided to patients while also reducing costs. However, they take fundamentally different tacts to achieve those goals. One pools numerous large employers together to negotiate rates with HMOs. The other also pools large employers, but instead bypasses the entire HMO system by directly contracting with medical providers in a competitive, market-driven economic model. I encourage you to analyze both cutting-edge programs.

Finally, we look at the long-term care needs for the growing elderly population. The aging baby-boomers will place an enormous strain on state resources as they reach the over 65 demographic. Currently, I am diligently engaged in finding a cost-conscious and health-conscious solution to this extremely important public policy issue.

On the economic front, we are pleased to report that California's economic expansion continues to break records and reach milestones. The unemployment rate has reached a 30-year low, thus allowing the greatest number of Californians to work in the history of the state. Furthermore, all the employed workers have kept consumer spending at unprecedented levels and have ignited the housing market. We have truly reached an economically historic moment.

As California's Chief Financial Officer, I strongly believe California cannot expect to continue its current economic expansion without adequate and comprehensive health care coverage for its residents. Unhealthy residents place an enormous economic burden on both business growth and state finances. In this time of historic prosperity, we must come together, take a leadership role and implement a far-reaching vision for a healthier California.

KATHLEEN CONNELL
Controller
State of California

California Economy

Controller's Review of 1999 and Outlook for 2000

The performance of the California economy over the past 5 years has been spectacular. By the end of 1999, the unemployment rate dropped to a 30 year low, job and income creation were fueling the largest consumer spending surge in the history of the state, and California exports were bouncing back impressively.

The collection of economic indicators for both the nation and the state clearly demonstrate that the economy remains strong and consumers feel good about it. Consumer spending on retail goods, cars, homes, and services is both unprecedented, and largely driving the economic expansion that is now in its 7th year in California.

The state economy has been especially strong because many of its premier industries principally serve a national and global market. No one industry dominates, even among the manufacturing sectors, which typically are the most vulnerable to recession abroad. Ten years ago, a major part of the economy was concentrated in aerospace, research and manufacturing. As that sector suddenly downsized, the state was left vulnerable. That kind of vulnerability is absent today. Biotechnology, semi-conductors, information processing, recreation, entertainment, tourism, apparel manufacturing, and construction all contribute to a broad-based and expansive California economy.

Consumer spending was prolific in 1999. Retail markets soared 9 percent during the first half of the year. The demand for homes pushed sales to all time record levels in California. Higher wages and salaries, accumulated wealth from the stock market, and historically low interest rates were the principal reasons for another strong year in residential real estate.

Both residential and non-residential building activity this year will exceed all other years of the 1990s. Commercial vacancies are at or near their lows for the decade in San Francisco, Alameda, Santa Clara, Orange, and Los Angeles counties, and more new commercial building than at any other time during the last 10 years is currently underway.

Labor Markets

The unemployment rate fell to 4.6 percent in December 1999, the lowest rate since 1969. More residents of California are currently employed than at any other time in the history of the State. (Figure 1)

Employment in the non-farm sector jumped by 391,000 jobs in 1999, a 2.8 percent increase, and the second best year of the decade for job creation in the state. Most of the jobs created were principally in construction, business services, retail trade, education, engineering and management, health services, social services, and recreation. Federal government, durable manufacturing, oil and gas extraction, and the farm sector continued to downsize their employment in 1999.

The momentum in job creation observed during the last half of 1999 is carrying forward into 2000. California labor markets will continue to create more jobs this year, though at a slower rate of increase. We expect non-farm job growth to decline to a healthy 2.6 percent rate in 2000.

Real Estate

Existing home sales jumped 7.5 percent in 1999 to an all time record high. The median selling price of homes in California advanced 8.5 percent to $218,000, the highest value on record. Among California regions, Santa Clara County posted the highest median selling value in 1999, at $402,875. At $393,000, the median selling price of homes in San Francisco was not far behind. In Los Angeles County, the median selling price during 1999 was $199,950.

With higher interest rates now prevailing in 2000, the outlook for home sales weakens. However, labor markets are expected to remain strong in the state this year. Together with the lack of available inventory and continued population growth, selling prices are not expected to retreat in 2000. The California Association of Realtors is forecasting an 8 percent drop in home sales and a 5 percent rise in home selling prices this year. (Figure 2)

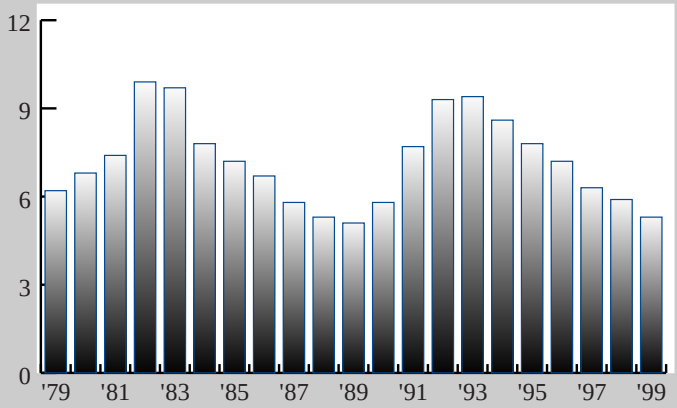
Residential Construction

The number of new homes permitted in the State last year was the highest since 1990. New residential units totaled 139,000, an 11 percent increase over total permits in 1998.

Figure 1

California Unemployment Rate

(Percentage)

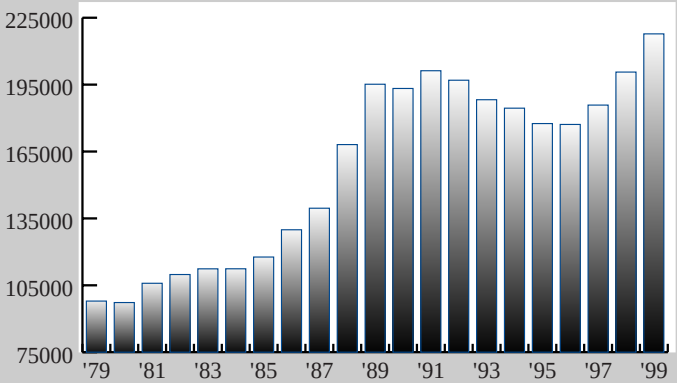


Source: EDD

Figure 2

California Median Home Selling Price

(Thousands of Dollars)



Source: CAR

While the increase is encouraging, this level of new home building remains very lean as housing is generally in short supply across the state, and accordingly expensive.

In both the northern and southern regions of the State, the number of new residential units seriously lags behind the growth of population and jobs in the state. Consequently, household densities continue to rise, as does the price of homes, especially in the coastal counties from Marin in the north to San Diego in the South.

Non Residential Construction

Office and industrial building vacancy rates fell to decade lows in most major cities of California. This has encouraged more commercial, industrial, and other non-residential building in the State. Last year, construction investment dollars increased 5.3 percent to the highest inflation adjusted total since 1989. The greater 7-County Los Angeles region led the state in new commercial and industrial construction last year, accounting for 55 percent of all commercial and industrial investment. (Figure 3)

Personal Income

Another year of double-digit stock market returns in 1999 resulted in large capital gains for California residents. Income from all assets, including financial assets, grew by more than 6 percent in 1999. Wages and salaries, representing 58 percent of total personal income, advanced nearly 7 percent in 1999.

Personal income tax receipts, the largest single source of revenue to the California General Fund, jumped 10.6 percent for the fiscal year ending June 30, 1999. Overall, general fund revenues advanced a healthy 7 percent for the fiscal year. (Figure 4)

The General Outlook

The momentum that fueled economic growth in California during the last half of 1999 continues unabated into 2000. It is difficult to detect any weakness in the economy at this time. Though a slowdown is forecast for the year 2000, the California economy will remain healthy. Despite recent Federal Reserve rate hikes, the demand for credit is strong and financial markets remain relatively vibrant.

Consumer spending will continue to push local economic growth higher. The fundamentals of personal income and job growth will see to that. If the long anticipated stock market correction occurs this year, consumer confidence will be shaken, unbooked wealth will decline, and spending will certainly be impacted. Barring a severe collapse of the financial markets, however, spending on retail goods, business and personal services, and homes is not likely to slow dramatically during the year.

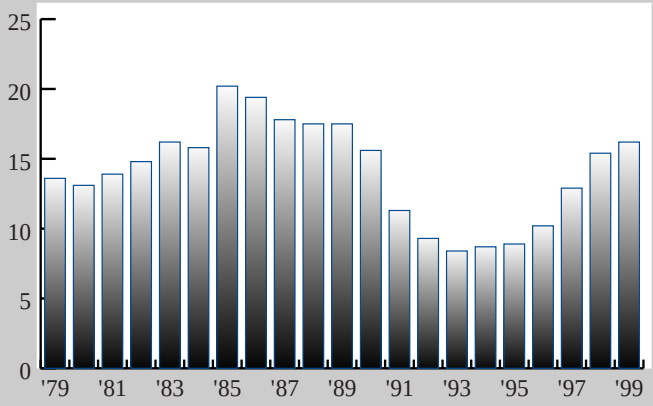
The general slowing of the California economy anticipated this year is influenced by higher interest rates and slower U.S. Gross Domestic Project growth. However, the economy of California is poised to remain stronger than the rest of the nation because our economy is more concentrated in high technology, information, multimedia, biosciences, and Internet development. The growth of these sectors dominated the creation of payroll and investment income in 1999, and that trend is not expected to diminish in 2000.

Furthermore, California's more affluent population base will provide reserve spending potential when the economy does begin to slow down. The extent of that slowing is largely dependent on the feedback of the U.S. economy, and what we believe is the impending contraction of the U.S. equities market. That, however, cannot be predicted with any certainty.

Figure 3

Commercial & Industrial Permit Value

(Billions of 1999 Dollars)

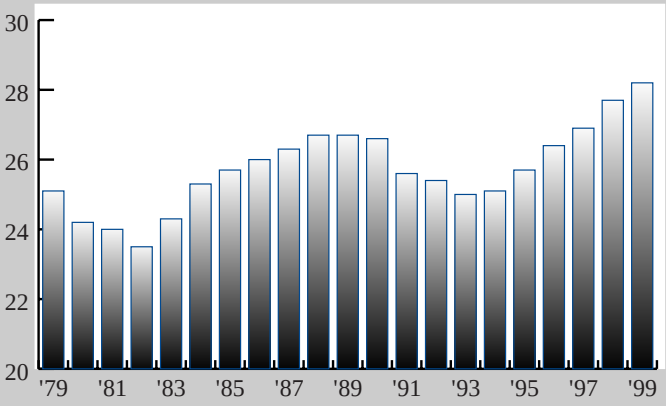


Source: CIRB

Figure 4

Personal Per Capita Income

(Thousands of 1999 Dollars)



Source: DOF

2000 Forecast by Controller's Council of Economic Advisors

Council Member	Employment Growth (Annual %)	Unemployment (Annual %)	Personal Income Growth (Annual %)	Res. Building Permits (Thou)
LA Economic Devt. Corp. (J. Kyser)	2.9%	4.0%	6.8%	152
Calif. Assn. of Realtors (G.U. Krueger)	3.0%	5.4%	6.4%	155
UCLA Anderson Forecast (T. Lieser)	2.7%	4.8%	6.1%	150
UC Berkeley, Center for Real Estate & Urban Economics (C. Kroll)	2.3%	5.0%	6.0%	139
Pacific Bell (J. Hurd)	2.6%	4.7%	6.4%	155
Bank of America (B. O'Connell)	2.4%	5.3%	6.3%	147
Center for Regional Economic Research (M. Schniepp)	2.5%	5.1%	6.4%	136
Mean	2.6%	4.9%	6.3%	148
Median	2.6%	5.0%	6.3%	150
State Controller	2.6%	4.8%	6.2%	150
1999 Actual*	2.9%	5.3%	6.4%	139

* "Actual" figures may vary from prior published figures to reflect new data that has become available.
Source: State Controller's Office; Council of Economic Advisors

The Importance of Healthcare in California

"…Californians'… expenditure on healthcare in 1999 was estimated at $63 billion."

The healthcare sector has become a dominant part of the U.S. and California economies. With 34.3 million Californians as of January 2000, their expenditure on healthcare in 1999 was estimated at $63 billion. Only food, housing, and transportation exceed healthcare as a principal household expenditure.

The healthcare industries include all of the services from conventional and alternative medical providers, biomedical research, medical device and supply manufacturing, and pharmaceutical research and development.

Thirty-two percent of the nation's biotechnology companies and 28 percent of high tech medical device firms are located in California. Overall, more than 800 companies and 65 university and private research institutions in California are actively engaged in healthcare technology.

Demographic fundamentals drive the demand for healthcare services and technology.

The changing demographics of California will mandate the need for more and improved healthcare services, products, and technologies between now and the year 2040. The principal reasons for the sharply increasing need are:

• The life span has increased, enabling people to live longer. Longer life mandates the need for more healthcare services to maintain quality of life in older age.

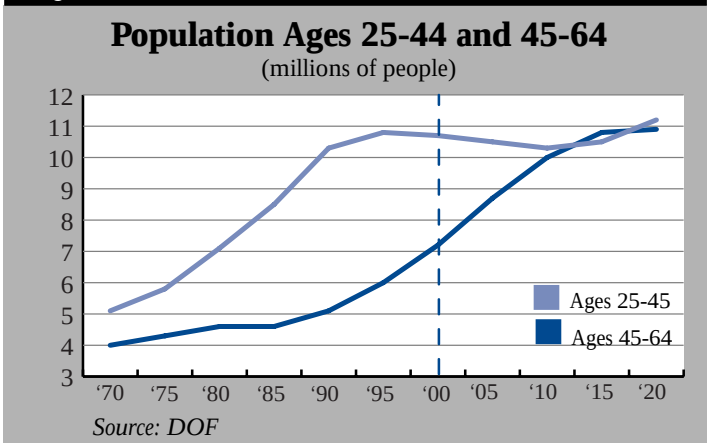
• The population of California is growing older. With a proportionately older age population, the demand for healthcare is rising sharply.

• With 78 million members in the U.S. today, the baby boom generation born between 1946 and 1964 is the largest generation in the history of the world. In California, the resident boomer generation is 68 percent larger than the generation before it, born 1919 to 1945. Today there are 9.8 million boomers in California.

• As boomers move into the older age population groups, the demand for healthcare and the cost of health care will rise sharply. This is because the average annual medical-care bill rises along a steep curve for older age groups. The demand for healthcare will rise steadily for the next 45 years, or until the youngest boomers today are in their 80s. (Figures 1 and 2)

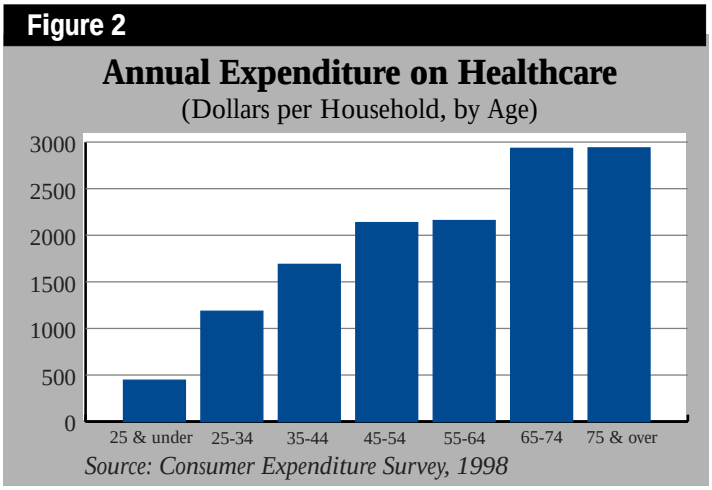
• The first boomers will turn 65 in the year 2011, the last in the year 2029. Sixty-five year-olds and over spend more on healthcare because

Figure 1



The 45 to 64 year old population group is the fastest growing age cohort in the State today. By the year 2012, this group will exceed the 24 to 44 year old group. The demand for healthcare will rise in tandem with the growth of the 45 to 64 year old population.

Figure 2



Expenditures on healthcare rise in tandem with a person's age. The amount a 65 year old spends on healthcare is 6.6 times the healthcare expenditure of a 24 year old.

they use it more. On average, an older person visits a physician 8 times a year, compared with 5 visits annually by the general population. They are hospitalized more than three times as often, stay 50 percent longer, and use twice as many prescription drugs. Medi-Cal and most private insurance programs require the elderly to pay part of their expenses, including a monthly premium for outpatient and physician services, a deductible for hospitalization, and the cost of all drugs.

• Gains in life expectancy have produced an unprecedented number of the oldest-old. In 1990, there were 293,000 over-85 year olds, and 3,600 centurians. In just 30 years, i.e., by 2020, there will be 728,000 over-85 year olds, and 9,300 centurians, an increase of 148 and 158 percent respectively. By 2040, the number of over-85 year olds will quadruple. 85 year olds spend 30 percent more on healthcare than 65 year olds, and 154 percent more than 35 year olds. (Figure 3)

The magnitude and direction of the industry

Currently, over 920,000 workers are employed in healthcare services in California. The healthcare technology industries directly employ another 120,000 workers. Together with the biotechnology and medical device manufacturing sectors, total employment in healthcare was just over 1 million workers, as of December 1999.

The composite healthcare and medical technology sector represents 7.5 percent of all wage and salary jobs in California, and another 300,000 self employed proprietors, such as physicians, chiropractors, psychologists, and alternative healthcare practitioners.

Income from payrolls to wage and salary workers totaled $46 billion in 1999, or 8.5 percent of total payroll income in the state. The average salary for healthcare services and the medical technology sectors is just shy of $40,000 per worker.

The medical device industry in California exports over $1 billion of medical instruments annually. More than 22 percent of medical instruments exported by the U.S. are manufactured in California. (Figure 4)

The magnitude of the industry, the related jobs, total payrolls, and the number of institutions, is immense. And the state of the industry will only increase over the next 20 years. The UCLA Anderson forecast of healthcare calls for total employment to nearly double between now and the year 2020. The share of healthcare employment will rises to 9 percent of all non-farm jobs in the state. During the highest growth years, 2002 to 2011, the rate of job formation in healthcare is double the rate of jobs for all sectors.

Summary

The importance of healthcare to the California economy cannot be overstated. Healthcare represents a pressing social concern because of the unprecedented demand for it by an aging and longer living population. Capital, labor, and technology in California have been drawn to the industry over time and the growth of these resources is surely to accelerate over the next decade.

The theme of this Controller's Quarterly addresses a number of issues which are paramount to the impending need for a modern healthcare policy for Californians in the new millennium.

"…over 920,000 workers are employed in healthcare services in California."

Figure 3

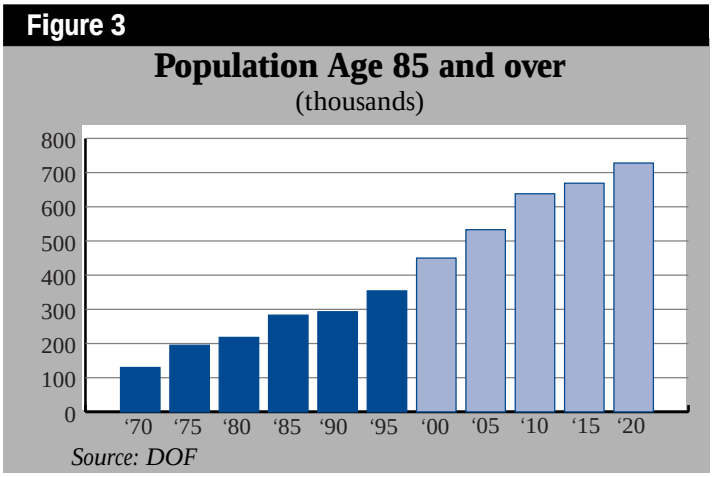
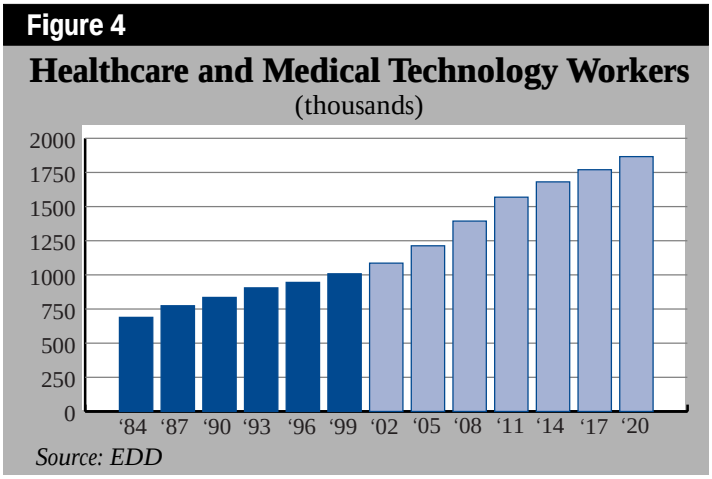


Figure 4



Health Insurance Coverage of Californians

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"California's uninsured population increased by 276,000 in 1998 to 7.3 million."

Health insurance coverage of non-elderly Californians continues to decline, despite the ongoing economic boom. The number of uninsured Californians reached 7.3 million in 1998—one in four of the state's non-elderly residents. The uninsured population in 1998 totaled 276,000 more than in 1997, an average monthly increase of 23,000.

One in six of the nation's uninsured population lives in California. But California accounted for one in three of the nation's increase in uninsured persons between 1997 and 1998—nearly three times its share of the U.S. non-elderly population. The state's increasing uninsurance is the result of public policies that have decreased Medi-Cal coverage in the face of flat job-based coverage.

Overview of Health Insurance Coverage[1]

Employment-based and privately purchased health insurance coverage remained essentially flat from 1995 to 1998—even as California fully recovered from the deep recession of the early 1990s. The proportion of non-elderly Californians who received health insurance through their own employment or that of a family member increased slightly, but not significantly, from 57.2% in 1995 to 58.3% in 1998 (Figure 1).

Health insurance purchased in the nongroup market ("privately purchased") is an option for those who do not obtain coverage through an employer and for self-employed adults—if they qualify and can afford it. Privately purchased insurance also remained flat, covering 4.4% of non-elderly Californians in 1995 and 4.5% in 1998.

For those who do not secure coverage through employment and cannot purchase it through a private source, Medi-Cal (California's Medicaid program) may be an option. But Medi-Cal is restricted to persons whose incomes are low enough to meet stringent eligibility requirements and who fit into one of Medi-Cal's eligibility categories (e.g., in a family with eligible children, a pregnant woman, a disabled non-elderly adult, or an elderly adult). The proportion of the non-elderly population that reported receiving Medi-Cal coverage, however, fell dramatically from 14% in 1995 to 12.8% in 1996, to 11.4% in 1997, and 11% in 1998.[2]

The decline in Medi-Cal coverage was likely due to several related factors. First, welfare reform altered federally funded public assistance programs to which Medi-Cal historically had been tied. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 tightened eligibility requirements for public assistance to immigrant noncitizens and separated eligibility for Medi-Cal from eligibility for cash assistance to families with children. Although families leaving welfare[3] could remain eligible for transitional Medi-Cal, many were not informed of their eligibility and did not receive it. Other low-income working families who had not received welfare were also potentially eligible but were not widely informed of this option. The combination of welfare reform's limits on receipt of public assistance and added restrictions on immigrants pushed many recipients into jobs being created by the improving economy. But most of the entry-level jobs they obtained paid low wages and did not offer health benefits.[4] Additionally, the stigma of the welfare office interview, required for eligibility determination, has kept many from seeking Medi-Cal coverage even when they are eligible.[5]

This dynamic—of flat employment-based and private insurance coverage plus declining Medi-Cal enrollments—pushed up the proportion of non-elderly Californians that is uninsured. The uninsured rate in 1995 (22.7%) appeared to improve slightly (but not significantly) as the state's economy began recovering from the recession, but then climbed with the enactment and implementation of welfare reform, rising to 24.4% in 1998—one in four non-elderly Californians.

California's Persistent Disadvantage

Compared to the rest of the United States, California's non-elderly population has lower rates of job-based insurance and higher uninsured rates. In 1998, California had a significantly higher uninsured rate (24%) than the rest of the country (17%).This higher rate of uninsurance was largely driven by California's lower rate of employment-based coverage (58% in California vs. 69% nationally). California's uninsured rate would be even higher if the state's Medi-Cal eligibility policies were less generous. In California in 1998, even after several years of decline, 11% of the non-elderly population obtained coverage through Medi-Cal, compared with only 8% in the rest of the United States.[6]

Figure 1

Health Insurance Coverage of Non-Elderly Californians, ages 0-64

Health Insurance Coverage	1995	1996	1997	1998	Change 1995-1998
Uninsured	22.7%	22.3%	23.8%	24.4%	1.7%*
Job-based insurance	57.2%	57.8%	58.2%	58.3%	1.1%
Privately purchased	4.4%	5.7%	4.8%	4.5%	0.2%
Medi-Cal	14.0%	12.8%	11.4%	11.0%	-3.0%*
Other	1.7%	1.5%	1.8%	1.8%	0.1%
Total	100% (N=28,710,000)	100% (N=28,940,000)	100% (N=29,520,000)	100% (N=29,870,000)	

Source: March 1996, 1997, 1998, 1999 Current Population Survey

Californians have had lower health insurance coverage rates for at least two decades. In rankings among the 50 states and the District of Columbia, California is now last in its proportion of non-elderly residents who have job-based insurance coverage. This low rate accounts for the state having the third highest uninsured rate (exceeded only by Texas and Arizona). (Figure 2)

Young adults, ages 19-24, have the highest rate of uninsurance of any age group. In 1998, only 46% of persons ages 19-24 had employment-based insurance, 4% were covered by privately purchased insurance, and 10% were covered by Medi-Cal, leaving 39% uninsured (Figure 3). In contrast, 68% of persons ages 40-54 had employment-based coverage, another 5% had privately purchased insurance, and 5% had Medi-Cal coverage, leaving only 19% uninsured.

These differences reflect the disparities that inevitably result from a health insurance system that relies on voluntary provision of health benefits by employers as the primary source of coverage. Young adults have high rates of enrollment in school and are just entering the labor market, resulting in low rates of job-based insurance, while individuals ages 40-54 are at their peak in the labor market, generating high rates of coverage.

The proportion of children up to age 18 that was covered by health insurance obtained through a parent's employment fell between these two extremes, with 54% covered by job-based insurance. One in five children (20%) was covered by Medi-Cal, the highest proportion of any age group—but well below the level in 1995, when one in four (25%) had Medi-Cal coverage.

Latinos continue to have the lowest health insurance coverage of any ethnic group. Just 40% of Latinos had employment-based coverage in 1998, compared with 70% of non-Latino whites. Since 1995, job-based insurance has remained relatively flat for Latinos and for non-Latino whites (whites), despite the economic boom. Latinos' low rate of job-based coverage is partially offset by Medi-Cal, which covered 17% of Latinos in 1998—a dramatic drop from 22% in 1995. Latinos' decline in Medi-Cal coverage exceeded their rise in job-based insurance, pushing up their uninsured rate by two percentage points. As a result, 40% of Latinos were uninsured in 1998, compared to 15% of whites.

Asian Americans and Pacific Islanders (AAPIs) have a lower rate of job-based insurance than do whites, but their rate in 1998 (61%) represents a gain compared to their rate in 1995 (58%). AAPIs' Medi-Cal coverage has fallen faster during this period (from 14% in 1995 to 8% in 1998) than job-based coverage rose, leaving 22% uninsured in 1998 (statistically the same as in 1995).

African Americans gained dramatically from the economic improvements of the late 1990s, with their job-based coverage climbing from 47% in 1996 to 55% in 1998. As with other ethnic groups, falling Medi-Cal coverage, from 25% in 1995 to 19% in 1998, left 23% uninsured in 1998 (statistically the same as in 1995). Other public coverage, such as through the military's health programs, also fell for African Americans.

(Unfortunately, the small number of American Indians and Alaska Natives in the California sample of the Current Population Survey results in very unreliable estimates that do not meet appropriate statistical standards. We therefore have excluded estimates for American Indians and Alaska Natives from this report.)

Californians who were either born in the United States or have become naturalized citizens are more likely to have employment-based coverage and less likely to be uninsured than noncitizens. In 1998, only 36% of noncitizens had employment-based coverage, compared to 63% of U.S.-born citizens and 59% of naturalized citizens. These rates are quite similar to those in 1995 for U.S.-born citizens and for noncitizens, but they appear to have declined markedly for naturalized citizens—perhaps due to the naturalization of more immigrants with lower levels of educational attainment or other factors that affected their ability to obtain employment with benefits.

An increasing proportion of U.S.-born citizens and noncitizens became uninsured as their Medi-Cal coverage fell—for U.S.-born citizens, from 14% in 1995 to 12% in 1998, and for noncitizens, from 17% to 9%. Naturalized citizens' Medi-Cal coverage did not change significantly between 1995 and 1998, nor did their uninsured rate, but their job-based coverage did fall, suggesting potential increases in their uninsured rate.

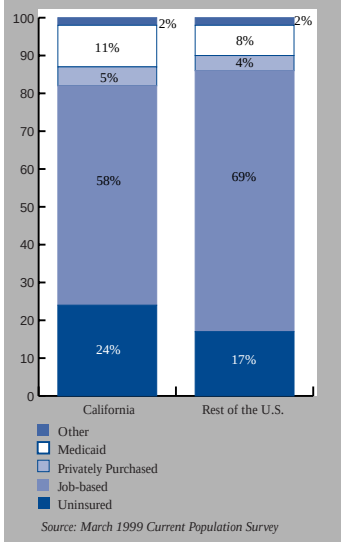
The fact that half of all noncitizens are uninsured is a public health and social justice problem of great magnitude. The state's 5 million noncitizens represent 17% of all non-elderly Californians and an important part of its labor force.

Excerpt from: HH Schauffler and ER Brown. The State of Health Insurance in California, 1999, Berkeley, CA: Regents of the University of California, January 2000.

"Job-based and privately purchased health insurance coverage remained flat despite the economic boom."

Figure 2

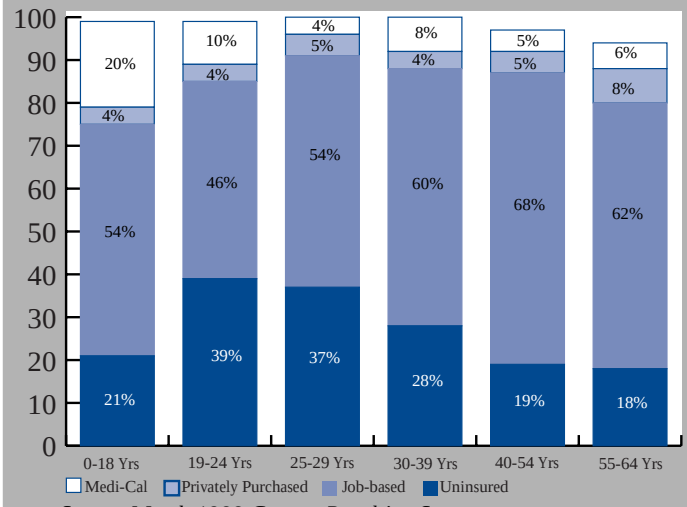
California Health Insurance Coverage



Source: March 1999 Current Population Survey

Figure 3

California Health Insurance Coverage by Age Group



Source: March 1999 Current Popultion Survey

References:

1 *All references in the text to differences in proportions between groups are statistically significant (p <.05) unless otherwise stated.*

2 *Persons identified in this report as covered by Medi-Cal are those who reported being on Medi-Cal (or were classified by the Current Population Survey as being on Medi-Cal) but who did not report having either employment-based health insurance or privately purchased insurance. These estimates, as well as those of other surveys, are generally lower than estimates derived from Medi-Cal administrative data.*

3 *Known nationally as Temporary Assistance for Needy Families, or TANF, and in California, as "CalWORKs."*

4 *Parrott S, Welfare Recipients Who Find Jobs: What Do We Know About Their Employment and Earnings? Washington, DC: Center on Budget and Policy Priorities, 1998; Loprest P, Families Who Left Welfare: Who Are They and How Are They Doing? Washington, DC: The Urban Institute, 1999.*

5 *Perry MJ, Stark E, Valdez RB, Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children, Menlo Park, CA: Henry J. Kaiser Family Foundation, 1998.*

6 *As noted above, Medicaid estimates derived from surveys are lower than those derived from administrative data.*

The Road Ahead: Challenges for the New Millennium

Patricia E. Powers — Chief Executive Officer, Pacific Business Group on Health

As the Pacific Business Group on Health (PBGH) enters the new millennium and begins a second decade of purchaser collaboration, we are at an important crossroad. While we are recognized as one of the nation's preeminent business health coalitions and are proud of our track record, much of our agenda remains unfinished. There is no doubt in our minds that the health care system today is better off than twenty, ten, or even five years ago. Progress in an industry as large and complex as that of health care means that change is rarely sweeping, rather it comes in fits and starts and is oftentimes frustrating. Yet we are optimistic that the momentum for moving forward will lead to more significant changes—and we are enthusiastic about our role in shaping these changes as responsible, value-based purchasers.

Eleven years ago, a group of large employers in California came together to collaborate, recognizing that even a very large purchaser could not affect the kind of changes that could be achieved by working in concert. The overarching goal of PBGH has not changed since our inception: to improve health care quality while moderating costs. We continue to believe that improvements in quality and information efficiencies are the linchpin to keeping costs reasonable in the long run. The coalition began with a focus on quality, conducting one of the first health plan satisfaction surveys in the country. In addition to improving quality, our other priorities include value-based purchasing through collective negotiations, advocating for electronic standardized information, and partnering with various stakeholders, including health plans, physicians, hospitals, and consumers.

Enhancing Our Leverage

Going forward, one of our goals is to enhance our leverage in the health care marketplace to more rapidly advance our goals. This is especially important given the consolidation that has occurred within the health care industry. Since 1989, PBGH has grown to 33 large private and public sector employers. Together these companies spend $3.5 billion annually to provide health care coverage to approximately three million employees, dependents, and retirees. Recent areas of expansion include assuming management of a small business purchasing pool from the State of California. Known as Pacific Health Advantage or the Health Insurance Plan of California (its State-given name), the pool represents more than 8,000 small firms, each with 2 – 50 employees.

Another growth spurt for PBGH occurred just this year when affiliate relationships were formalized with two regionally based coalitions. One coalition, the Silicon Valley Employers Forum, consists of about a dozen high-technology firms located in the Santa Clara area. The North Bay Employers Coalition includes seventeen mid-size businesses that have been working together to improve health in Sonoma County. These like-minded companies are eager to work with PBGH, especially in the areas of quality and information improvements.

Other strategic alliances forged on the national front include partnering with other coalitions and multi-state employers to develop a common request for proposal (RFP). This RFP was used in sixty-six markets last year. In addition, PBGH is participating in national quality and data initiatives.

Focusing Our Buying on the Delivery System

A second key goal for this year and beyond is to obtain better information on what is happening within the delivery system. Because PBGH companies employ workers who are scattered throughout California, we currently purchase care through health plan networks. Yet with respect to both cost and quality, there is considerably greater variation amongst physicians and hospitals. Furthermore, unlike many other states, here most decisions related to care are delegated to the delivery system. Most importantly, consumers care more about what is happening with their doctor, rather than their health plan. For these reasons we are partnering with both plans and providers to obtain valid, comparable information on the delivery system. While in the near term we will continue to buy through health plans; we are also exploring other models, such as direct contracting and other alternative arrangements.

Creating the Right Incentives

Over the years we have put several mechanisms in place to promote high value health plans and providers. These incentives include designating Blue Ribbon awards based upon our strategic initiatives of quality, cost, data, and partnering. The winners are highly visible through our open enrollment materials, websites, and press releases. This year we are requiring all health plans to contract with all Blue Ribbon providers and are encouraging employers to create employee enrollment incentives for Blue Ribbon health plans. Some employers, for example, discount the premium for a Blue Ribbon health plan.

Going forward, our hope is to strengthen our incentives by encouraging health plans to pay more to high performing doctor groups and hospitals. We are willing to pay those plans which do so a higher premium. In collaboration with our health plans we are exploring the possibility of creating benefit design features that encourage employees to select high value doctor groups and hospitals. In other words, choice will not be restricted, but employees who select a hospital with significantly better survival odds, for example, will pay less than someone who selects a hospital with relatively high mortality rates. Informing our employees (as well as ourselves) will lead to better decisions and better care over time.

Conclusion

This is a tumultuousness time for the health care industry nationwide. We hope to turn challenges into opportunities by sticking to our long-term agenda of improving quality and information in order to keep costs reasonable. Purchasers, whether they be public or private, large or small, regional or national, share a common interest in keeping their employees safe, healthy, and productive. PBGH's mission and sustained commitment as a purchaser driven coalition will continue to support this interest. We are well positioned for the road ahead.

Consumer's Choice

The Buyers Health Care Action Group History

The Buyers Health Care Action Group (BHCAG) is a group of Minnesota's largest employers working together to redefine the current healthcare marketplace. Over 135,000 employees representing more than 25 companies, including 3M, Honeywell, Target and Pillsbury, have joined BHCAG. BHCAG members don't buy health care through traditional HMOs, but rather the BHCAG member companies contract directly with medical groups, known there as "care systems," in order to open the current healthcare system to competitive market forces. This in turn increases its members' quality of care and reduces overall costs.

In 1993, BHCAG's Choice Plus program was formed and in 1997, embarked upon implementing a medical system that fundamentally changed the manner in which healthcare has been delivered the past few decades. The innovations included a risk-adjusted financing model, a data intensive rating system on both quality and cost of healthcare, and a system that allows members to choose almost any doctor they wish. These innovative changes have allowed BHCAG to answer many of the complaints and the problems typically associated with the HMO system. BHCAG has proven that the current healthcare delivery system still has plenty of room for improvement.

BHCAG instituted an innovative financial hybrid of the old fee-for-service approach and managed care's fixed -allowance, or capitation model. Each medical group determines their total cost for their enrolled patient population, which BHCAG translates into a rate for each service. Every quarter, the doctors and BHCAG go over the bills and make a comparison. If the doctors have come in under the cost projections, they may get a higher "hourly rate" for their work the following quarter as long as their lower costs were because of efficiency and weren't due entirely to having seen healthier patients. If they are over budget, BHCAG looks to see if a flu epidemic or something drove medical costs up and in that case does not impose a penalty. But if the medical bills are high because the doctors were inefficient by ordering unnecessary tests, they get a lower rate the next quarter. This risk-adjusted system allows the doctors to actually treat even the sickest of patients without the worry that their businesses might fail financially. Unlike the HMO model, the doctors are no longer forced to chase after the healthiest patients while spurning the sick ones.

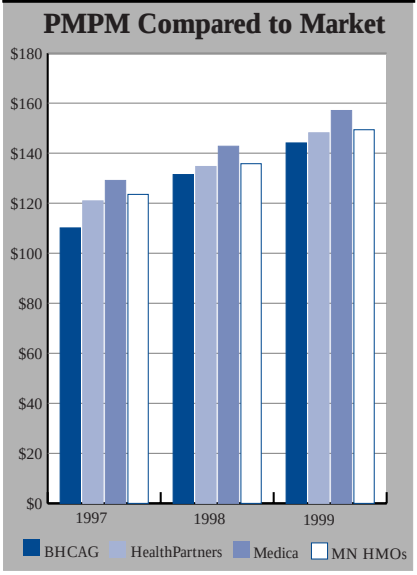
Informational data is a key component of not only cost determination, but also quality of care. BHCAG keeps extensive records on the cost data for each patient, doctor and procedure. But unlike the HMOs who also keep similar data, summaries of this information (without patients identified) are readily available and shared with any medical group that needs it. Each doctor can know exactly what other medical groups or care systems cost patients, and can adjust their own medical group's price accordingly. They also know the price each specialist charges and can refer their patients to the most cost efficient ones. Under the HMO system, many doctors would get penalized for sending their patients to a high-priced specialist even though the doctors were never given any cost data, which showed the prices each specialist charged. On the member side, each medical group is placed into a publicized cost tier every year which determines what members pay each month for coverage and which members use to determine whether they wish to continue with their current medical group or join a new one. This freedom of cost information allows the entire competitive model to work more efficiently.

Besides cost data, quality of care data is reported and utilized by members when choosing their medical group. A sample of members fill out comprehensive, semi-annual quality of care surveys about their medical group provider. This data is then compiled and distributed to all members and medical groups within the BHCAG network. In turn, all members and doctors are able to see how they rank against their competitors. In the HMO environment, quality of care surveys are rarely reported, or if they are, they show the results averaged across all the medical groups in an HMO's network. This gives the doctors very few incentives to provide higher quality medical care. BHCAG's medical group ranking systems for both cost and quality of care give members the option to choose a medical group which most closely fits their medical and financial priorities and also makes the medical groups publicly accountable for their medical practices and costs.

The cost savings with the BHCAG financial model have been impressive as their rates of increase have continued to stay below those of their major HMO competitors. The "Per Member Per Month" cost (pmpm) for BHCAG in every year has been lower than HealthPartners, Medica and Minnesota's other HMOs (Figure 1). For instance, in 1997, BHCAG's pmpm was $110.12 versus HealthPartners' $120.93 and Medica's $129.10. Much of the pmpm cost savings can be attributed to BHCAG's lower administrative costs. In 1998, for example, BHCAG only spent 11.02% of their total budget on administration versus HealthPartners' 13.46%, MN HMOs' 17.59% and Medica 22.33%. BHCAG averaged a greater than 10% administrative cost savings in comparison to their competitors from 1996 to 1998. It should be noted that reliable 1999 data is still being compiled. Even though BHCAG utilizes a data intensive system to compile and report cost and quality of health care, they are able to keep their overall administrative costs contained.

BHCAG has successfully melded cost reduction with health care quality increases by using the traditional market-driven business formula. Allowing a competitive health care market to flourish has unleashed a tremendous bounty of health care innovations that have greatly benefited all patients. The BHCAG model will continue to prevail as patients grow to expect high quality health care coupled with lower costs while also having a choice of doctors and plentiful information at their disposal.

Figure 1



Will We Move to a War Footing to Zap Unreliable Health Care Quality?

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Quality of American health care is broken. Reports in 1998 and 1999 by the National Academy of Sciences could not be clearer, citing "widespread and serious" defects, carrying a "great burden of harm" to Americans.

The extensive research evidence cited by the Academy indicates that the combined risk to an average American with an average health problem of not receiving needed services ("underuse"), *or* receiving services bringing more danger than likely gain ("overuse"), is roughly 50%. Further, even if an optimal treatment plan is selected, failures in treatment plan execution ("misuse") in hospitals alone avoidably kill the equivalent of a fully loaded jumbo jet of Americans every day. Five times this number are avoidably disabled.

"…failures in treatment plan execution ("misuse") in hospitals… avoidably kill the equivalent of a fully loaded jumbo jet of Americans every day."

Current evidence also indicates that, contrary to popular belief, this 50/50 quality reliability long preceded managed care; it is no better in other industrialized countries; and current improvement efforts are insufficient to make much of a dent.

The Academy is also clear that the fundamental drivers of unreliability are not "bad people." American doctors, nurses and health care workers are fully capable of delivering high quality care and strive to do so. However, their work methods are woefully undermatched to the complexity of modern medicine. The design of physician and nurse work assumes that human minds can dependably store, recall, detect, and act upon thousands of important intersections between individual patient information and medical science. Expansion of medical science made this impossible long ago.

There is little recognition of the mismatch. Computer systems to aid physicians in coupling complex patient information with up-to-date medical science to identify the best treatment options are rare. The redesign of clinical work to assure reliable treatment execution is also rare. For example, pre-surgical preparation for amputations does not routinely include marking the opposite limb with a "not this side" warning.

To assure reliable quality, health care delivery systems require fundamental re-engineering, equivalent to what occurred in commercial aviation. Driven by regulation, market considerations, and pilot self-preservation, commercial aviation took a complex and risky technology producing very high crash rates and re-engineered it to very high levels of quality reliability. Three questions govern whether we will replicate this progress in health care.

First, how aggressively will we advance the collection and public release of valid comparative performance measures for doctors, doctor groups, hospitals and health plans? Quality unreliability is largely invisible to both sides of the health care market. This blocks everyone's grasp of the magnitude of the problem and our ability to reward excellence. More important, it removes a compelling case for change. Efforts to improve aviation benefited greatly from the stark visibility of quality failure. Stark, ongoing public report cards on health care quality failure could play a similar role.

Second, for what pace of electronic information systems uptake should the health industry be held accountable? The answer affects our ability to produce inexpensive quality report cards and improve actual performance. Much of today's limits on measuring and managing quality flow from grossly underdeveloped and *underconnected* information systems in hospitals and physician offices. For most major treatments, we lack a rudimentary electronic data set for patient outcomes, patient risk factors, and health care processes. This is a voluntary handicap, for which the remedy is known and conveyed in well-conceived blueprints, such as the National Committee for Quality Assurance's 1998 "Roadmap for Health Information Systems." Poverty of information systems also impairs real-time quality assurance. For most treatment risks, such as physician prescribing errors, we lack reliable computerized protection.

The Pacific Business Group on Health has led the development of a multi-stakeholder plan for information systems breakthrough in California (www.calinx.org); but stakeholder efforts have not matched the degree of deficit. The health industry has acclimated to flying blind and is tolerant of its associated disability. Further, the need for investment comes at a moment of perceived economic distress and organizational turmoil in the health industry.

Third, what effort will we make to develop more savvy, value-seeking health care consumers? Today's reluctance on the part of purchasers to move enrollees to higher value health plans or providers reflects fear of enrollee backlash. The backlash originates in consumers who default to familiarity and customer service as their sole means of value assessment

and don't comprehend the serious consequences of performance differences between providers. Investment in consumer knowledge and navigational skills would encourage purchasers and health plans to offer narrower, quality-focused provider networks.

Comparative performance information, clinical information systems, and value-seeking customers will allow the market's invisible hand to sculpt two essential changes: an initial re-engineering of health care tailored to the complexity of modern medicine, and ongoing quality management on a par with other high risk industries such as aviation. These carry the potential for breakthrough in consumer benefit on a scale not achieved since American medical education and licensing reforms in 1910.

The size of the gain, and how long we will wait, depend on private purchasers, organized labor, consumer groups, government accreditors, insurers, providers, the information technology industry, and the media. Each needs to accept the war footing and inter-stakeholder mobilization necessary to fix a problem of this magnitude and longevity. The country that transformed vacant California mudflats into high-volume Liberty Ship factories within a year can zap unreliable health care quality. Will we?

Long-term Care Coverage

In the year 2020, when most of the Baby Boom generation reaches age 65, the over 65 demographic in California will have exploded to 6.4 million from the current 3.7 million. During the next 20 years, this group will shift from high-earning revenue generators to a dependent population, placing a huge financial burden on the state's long-term care health system.

California currently spends over $5 billion per year on long-term care coverage. With the elderly population more than doubling, and related health care costs projected to dramatically escalate, long-term care has become a crucial area of concern for state policymakers.

The disabled elderly must currently rely on their own resources or, when those are depleted, turn to Medi-Cal for their long-term care payments. Due to the high cost of long-term care (a year in a nursing home costs an average of $47,450 in 1999), many residents who desperately need that care will do without it or require state assistance to pay its costs. In 1997, 68 percent of nursing home residents were dependent on Federal Medicaid or state-funded Medi-Cal to finance at least some of their care. Furthermore, long-term care expenditures for the elderly are projected to more than double in inflation-adjusted dollars between 1993 and 2018 because of the aging of the population and price increases in excess of general inflation.

Unfortunately, most residents do not have any long-term health insurance coverage. The Health Insurance Association of America's 1998 survey showed that only 300,000 long-term care policies were purchased in California, which is equivalent to a 7.21 percent market penetration. A higher insurance penetration rate would not only provide a financial safety net for residents, but also a net savings to California's taxpayers in lower long-term care costs.

California's policymakers should explore ways to encourage long-term care insurance coverage. Numerous states have already passed tax credit or tax deduction legislation targeted either at individual buyers or employers to increase the long-term care insurance penetration rate. Proactive and visionary public policy legislation in the area of long-term care insurance would have a beneficial impact on the finances of both the Baby Boomer generation and the State of California.

"…long-term care expenditures for the elderly are projected to more than double in inflation-adjusted dollars between 1993 and 2018…"

Patient Safety and the American Health Care System

By David M. Lawrence, MD
CEO, Kaiser Foundation Health Plan and Hospitals, Inc.

A Quiet Crisis

On November 30, 1999, the Institute of Medicine (IOM) of the National Academy of Sciences released the results of an intensive multi-year study of healthcare quality in the United States. Earlier results released in *JAMA* in September 1998 indicated the seriousness of the situation. I worked with colleagues on both studies, and I agree wholeheartedly—but unhappily—with what they showed:

Serious and widespread quality problems exist throughout American medicine. These problems…occur in small and large communities alike, in all parts of the country, and with approximately equal frequency in managed care and fee-for-service systems of care. Very large numbers of Americans are harmed as a direct result. Quality of care is the problem, not managed care.[1]

The results released late last year by the IOM found that as many as 98,000 people die every year in hospitals alone due to medical errors. That's more deaths yearly than are caused by motor vehicle accidents, breast cancer, or AIDS. Extrapolate the data in those studies to healthcare in general, including care provided outside the hospital, and the numbers are even more staggering.

"…as many as 98,000 people die every year in hospitals alone due to medical errors."

The cost is high. In dollars, somewhere between $17 billion and $29 billion a year. Half that cost goes to healthcare—added expense for hospital costs due to an adverse drug reaction, for instance. The other half often comes out of a patient's pocket, because insurance premiums go up when healthcare costs more, and dollars spent to repair mistakes are dollars not going to preventive, crucial care.

Some Costs Are Incalculable

Worse, in some ways, are the costs that can't be measured.

The fragile trust a patient has for his doctor can be broken when harm is done because of a mistake. The physical harm done to someone who should have been healed can be permanent. Morale in healthcare settings suffers when the quality of care is low. And society loses when work productivity is lost, children miss schooldays, and a community loses the contributions of its members.

Two thirds of health care accidents are preventable. (The other third are results of unexpected complications of treatment, such as a life-threatening allergic reaction to penicillin.) And those frightening numbers do not include the impact of underuse or overuse of medical care. Fatalities from these quality problems, added to those from accidents, would significantly increase the number of deaths from accidents. You can see that we have a problem.

To take a closer look, a group of us began meeting 2 years ago with the support of the Kennedy School of Government at Harvard. Our purpose was to understand the causes of the problem and to develop and implement solutions.

The airline industry became our model. Commercial aviation-related fatalities have been reduced by 80% from 1950 to 1990. In the face of a dramatic increase in the volume of commercial air traffic in the 1990s, that industry has kept improving its safety record.

There are many reasons for the improvement—and they contrast sharply with what we know about healthcare.

Commercial pilots do not fly alone. They are members of a coordinated group of professionals trained to work as a team, especially in emergency situations.

- We know that physicians work more safely and effectively when they practice in teams, yet more than three quarters of physicians practice alone[2] or in small, single specialty groups. Consequently, they're less able to learn from peers or share experiences and new information. Most medical care is fragmented. Professionals struggle to work together in well-oiled teams.

Most commercial pilots have to pass regular examinations to demonstrate their knowledge and skills. They undergo recertification, including testing in flight simulators, to ensure that they can handle a wide variety of flying conditions and emergencies. They must stay up-to-date on changes in regulations, policies, and flying techniques.

- To stay current with rapidly changing care practices, physicians and other health professionals must sift through a mountain of medical articles that grows bigger by the day. The inability for a solo-practice physician to keep up with new information has led to wide variations in medical practices based on when and where a physician was trained and what community she practices in, rather than on current science.[4]

In aviation, data from "mistakes" are used for improvement. Data are collected and analyzed on both accidents and "near-misses." The data are used to identify accident and near-miss trends.

- Rigorous quality assurance and quality improvement systems have been slow to develop outside of the hospital—even though two thirds of medical care is delivered in outpatient settings.
- Only a few healthcare organizations have begun to employ the systems needed to provide safety-related training for physicians and other professionals.

The leading commercial airlines have created a culture of safety that includes protecting the jobs and legal status of those who provide information about near misses and accidents.

The aviation industry knows it cannot rely on perfect performance by individuals to ensure safety for passen-

gers. Robust safety systems ensure that human and mechanical errors occur less often, and when they do, they are less likely to result in tragedy.

• The culture of medicine embraces the expectation of perfect performance. This is a dangerous assumption. When something does go wrong—as it will, given the lack of shared knowledge or safety systems to help prevent errors—the mistake must be laid at the feet of someone who hasn't lived up to expectations.

• Medicine operates in a culture of blame, founded on malpractice and public accountability practices.

Finally, and perhaps most important, passenger safety has been the central issue for consumers, commercial aviation companies, and aviation-related policy and regulation.

• The public debate in healthcare has thus far focused on choice, access, and financing. Patients just assume – wrongly, as the evidence shows – that they're safe.

Translating Lessons to Healthcare

What can we learn from the aviation story? The critical lesson is this: To improve our safety record, we must rely on the strengths of organizations, rather than on individual people. We must change the way healthcare works for most Americans. Here's how:

• Group practice (not unionization) can help doctors improve their care to patients. High-performing multispecialty group practices enable physicians to share data, stay more current, monitor their quality, and provide more care continuity for patients.

• Well-organized integrated care delivery systems bring together the structure, expertise, experience, services, support systems, and incentives required to improve safety and care outcomes.

Here's an example of something we're doing in California to improve patient safety that can only be accomplished in an integrated system:

A team of doctors, nurses, pharmacists and others focused on adverse drug events has identified over 120 pairs of drugs that sound alike or are spelled similarly, to target for intervention at appropriate points in the medication use process (procurement/purchasing, storage, prescribing, preparation and dispensing, and administration). They have also targeted 6 "high alert" medications identified where consequences of errors can be devastating. As with the look alike/sound alike medications, interventions for the high alert medications will be aimed at appropriate steps in the medication use process.

A physician working in a solo or even a small group practice would not have the resources to create those kinds of safety systems.

We spent 1999 collecting information about all the patient safety initiatives going on nationwide throughout Kaiser Permanente. This year, we'll look at them all collectively to see what else needs to be done and what kind of coordination we can bring to bear on the individual efforts. Only a large integrated system like Kaiser Permanente can leverage its size and scope to bring about this kind of systematic change.

Improvements in patient safety pay for themselves. Dr. Donald Berwick, president of the Institute for Healthcare Improvement, estimates that we would reduce the nation's healthcare bill by 30% — $333 billion — if we applied these principles across the healthcare system. It costs less to do the right thing.

The Real Patients' Rights Issue

Still, we have a challenging road ahead. Our science, our technology, our medical care, our understanding of what works and what doesn't in medicine, are the best in the world and getting better.

But the safety with which care is delivered in this country is compromised by the delivery system through which most Americans receive it. That fragmented, unorganized system is more than 100 years old, and can no longer do the job. It is obsolete.

We know that safety will be compromised further in this system as the science expands and our technologies grow more powerful in the coming decade of unprecedented breakthroughs that most observers foresee.

We know that the starting place for improved patient safety is the formation of organized systems of care that include groups of physicians practicing in carefully structured and supported teams with other professionals, and that are focused on continuously improving the safety of the care they provide to their patients.

With your help, we can move forward with the task of building a healthcare system for the 21st century that delivers what the patients, families, and citizens of this country expect and deserve — safe medical care.

This is the real patients' rights issue: the right to safe care that can occur only if we make fundamental changes in the way we organize and deliver the remarkable care we now have available to improve the quality of our lives.

"There is in the worst of fortune the best of chances for a happy change."[5]

"Improvements in patient safety…would reduce the nation's healthcare bill by 30% — $333 billion…"

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Consequences of Lack of Health Insurance

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The consequences of being uninsured include failure to seek needed medical care because of cost, reduced access to preventive care and health promotion services, and poorer health status.

Failure to Seek Needed Health Care

Health insurance coverage is intended to reduce cost as a barrier to seeking needed care and to protect families from severe financial loss if expensive treatment is needed. It is often difficult to find private providers who will care for uninsured patients. Thus, many uninsured persons must depend upon the public health care system to act as a safety net and provide needed services. However, many counties, which bear the burden of this responsibility, do not have the resources to provide adequately for the needs of the community being served.

Among the insured population, the comprehensiveness of the benefit package and the cost-sharing features of policies determine the extent to which cost remains a barrier. Optimally, cost-sharing provisions should be set at nominal levels; high enough to create cost-consciousness among consumers, but not so high as to prevent them from seeking necessary care. In some cases, monthly premiums are kept low and deductibles and co-insurance or co-payments are set at high levels, using insurance more to protect patients from the catastrophic costs of illness than to pay for lower-cost or routine care. Insured persons who do not have coverage for specific conditions or services that they need and persons who face high cost-sharing provisions are often said to be "underinsured." Such individuals have insurance, but it is insufficient to meet their health care needs.

This problem is less significant for insured populations, with the exception of Medi-Cal recipients (Figure 1). In 1999, a much higher proportion (16%) of Medi-Cal recipients reported that they did not seek needed health care services due to cost barriers, as compared to 6% of those in HMOs and 4% of those in PPOs. Since many individuals with Medi-Cal coverage cycle on and off of eligibility within a single year, they may not have been covered by Medi-Cal at the time they experienced cost as a barrier to seeking care. Continuous eligibility for Medi-Cal could greatly reduce this problem for Medi-Cal recipients.

Among the uninsured, more than one in three (34%) did not seek health care in 1999 when they needed it due to cost. This rate is much higher than the rates for the insured population, regardless of type of coverage. Thus, a substantial number of the uninsured delay or avoid seeking needed health care services because they cannot afford the out-of-pocket costs. The future health consequences associated with this behavior can be severe.

The extent to which the cost of care acts as a barrier varies, not only by insurance coverage, but also by income, firm size, health status, and ethnicity. Those who were most likely to report cost as a barrier to needed care in 1999 include:

- 22% of those whose income is less than 200% of poverty, compared to 7% of those with incomes greater than 200% of poverty;
- 17% of those in firms with one employee, compared to 6% of those in firms with 101 or more employees;
- 20% of Latinos and 15% of African Americans, compared to 9% of non-Latino whites; and
- 25% of those who reported fair or poor health status, compared to 11% of those who reported excellent or good health status.

Not surprisingly, those groups who were least likely to have any health insurance coverage were also the most likely to report that they did not seek health care when they needed it in the last year due to the high cost. Thus, not only do a substantial number of Californians not have access to health insurance coverage, many are unlikely to seek medical care when they need it.

These findings, similar to those we have reported previously, continue to be very troubling, because a delay in getting treatment for health problems early on can lead to far more serious health problems later. The need for policies and programs to ensure that all Californians have access to primary care and acute care services when they are ill or injured continues to be great. Cost should not be a barrier to seeking needed health care.

Figure 1

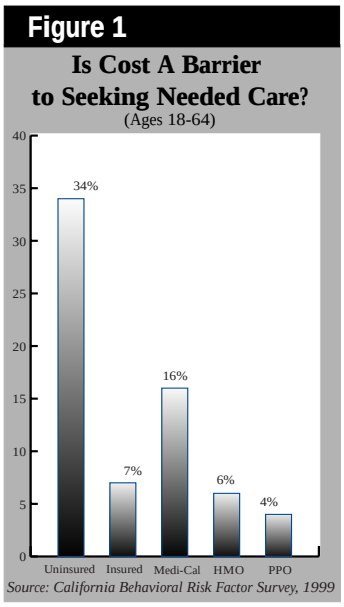
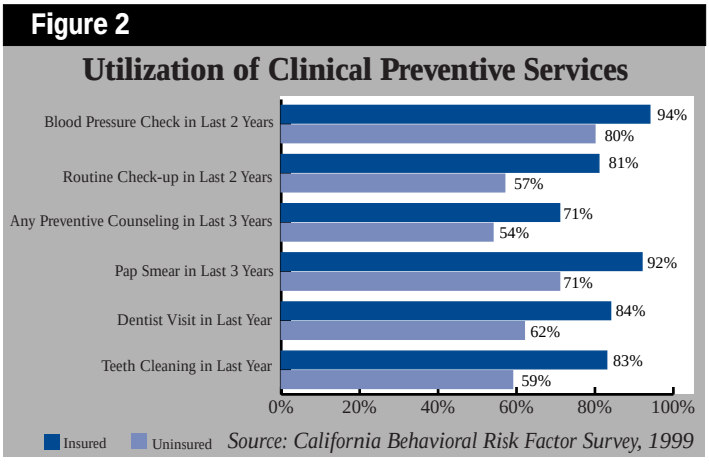


Figure 2



Reduced Access to Preventive Care

It has long been known that lack of health insurance is associated with lack of access to preventive care. Many clinical preventive services have been shown to be both effective and cost-effective in reducing disease and preventing premature death. A substantial percentage of uninsured adults in California do not have access to these important services (Figure 2).

For every clinical preventive service we examined, including blood pressure screenings, routine check-ups, preventive counseling, Pap smear tests in the last three years for women, dentist visits, and teeth cleaning, uninsured adults in California had significantly lower rates of receiving recommended care than did insured adults.

These findings suggest that, at a minimum, much more effort is required to ensure that access to preventive care is expanded for the uninsured—particularly for the early detection of cervical cancer in uninsured women—by increasing access to affordable health insurance that covers comprehensive preventive care and by increasing the ability of the public health system to provide these services for the uninsured.

Prevalance and Prevention of Risk Factors for Chronic Disease

The uninsured adult population in California also has a higher prevalence of risk for selected chronic disease risk factors than the insured population (Figure 3). The differences are particularly strong for rates of smoking, which is 19% in the adult insured population compared to 34% among the uninsured, and of being overweight, which is 36% among the uninsured compared to 31% in the insured adult population. The difference among the rates of acute drinking by insurance status is not significant.

The uninsured adult population is also much less likely than insured adults to participate in health promotion programs that can reduce their risk (Figure 4).

Health Status of Uninsured Adults

Uninsured adults in California have poorer health status and higher rates of preventable risk factors for future disease and injury than those who have health insurance. In other words, those most in need of health care and preventive services are least likely to have access to them.

California adults without health insurance, regardless of their working status, are more than twice as likely to report their health as fair or poor (21% vs. 10%) and less likely to report their health as excellent or good (79% vs. 90%) than insured Californians (Figure 5).

This is not surprising given the above findings that uninsured adults in California are less likely to seek medical care when they need it, to receive preventive care, to participate in health promotion programs, and to have higher levels of preventable risk factors compared to insured adults. This finding is also likely due to the fact that poor health status is strongly and inversely related to income. Among adults with incomes below 100% of poverty, 28% report they are in fair to poor health compared to 16% of those with incomes between 100% and 200% of poverty, and only 6% of those with incomes greater than 200% of poverty.

The underwriting and premium pricing practices of the health insurance industry limit coverage and increase the cost of insurance to high-risk individuals as documented in our 1997 report, *The State of Health Insurance in California*. Given this situation, it is logical that the rate of uninsurance continues to be higher among adults who are in poorer health and who are also low-income, as we have noted in previous reports. This finding emphasizes the need for increasing access to effective health promotion and disease prevention services, which have been demonstrated to reduce risk levels, detect disease at its early stages, and promote the health of the population. To achieve this objective, programs available through local health departments and other safety net providers as well as health insurance that covers comprehensive preventive, primary, and acute care services should be made more accessible.[1]

Excerpt from: HH Schauffler and ER Brown. The State of Health Insurance in California, 1999, Berkeley, CA: Regents of the University of California, January 2000.

References:

[1] *U.S. Preventive Services Task Force. Guide to Clinical Preventive Services. Second Edition. Baltimore, MD: Williams and Wilkins; 1996.*

"Nearly one-third of uninsured adults did not seek needed health care in 1999 due to cost."

Figure 4

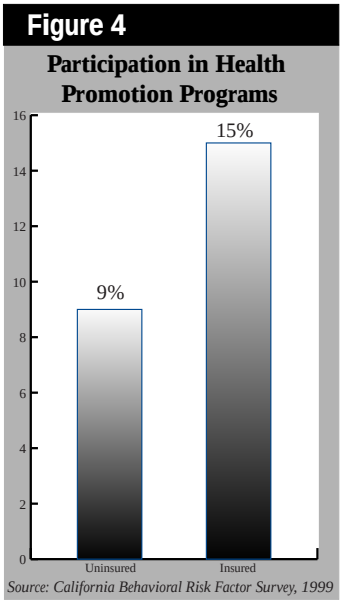


Figure 3

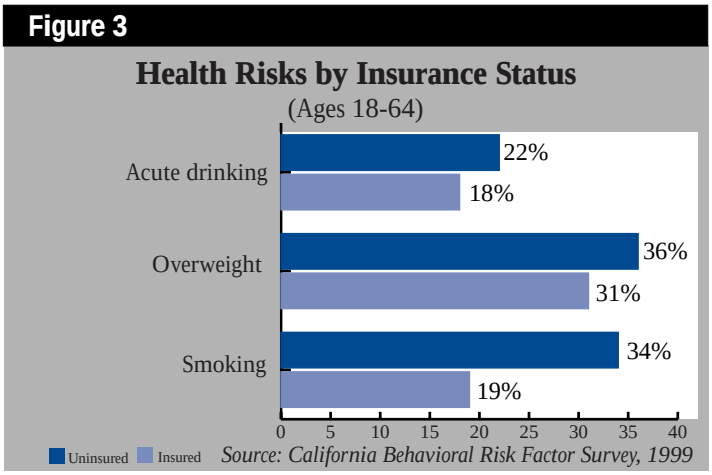
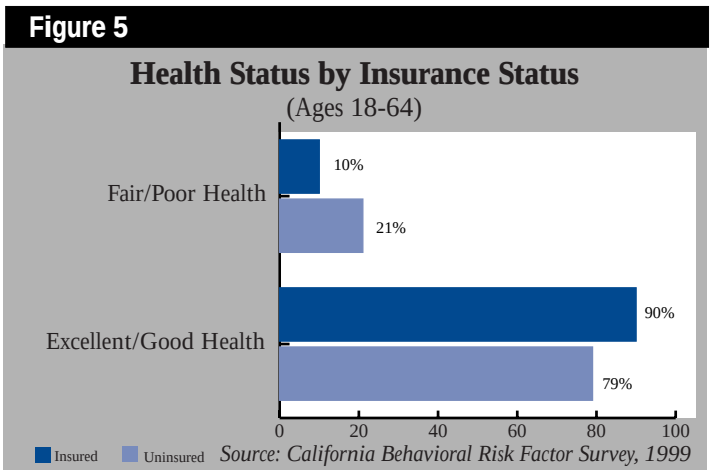


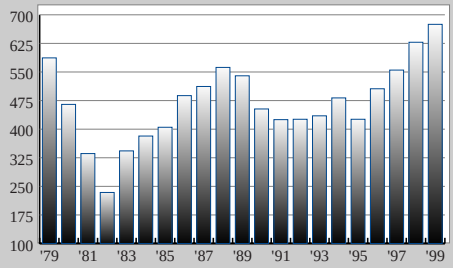
Figure 5



Facts and Figures

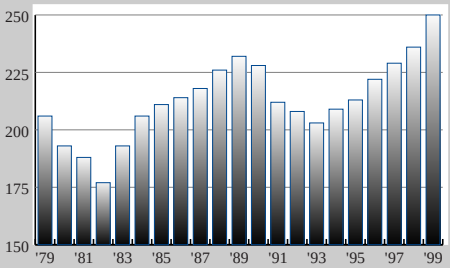
Important Information About California

Existing Home Sales
(Thousands of Homes)



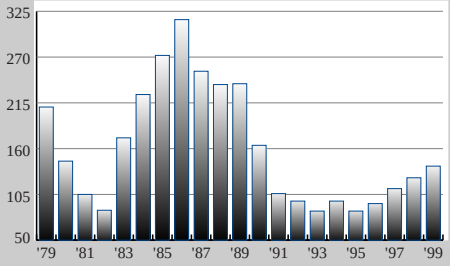
Source: CAR

California Taxable Retail Sales
(Billions of 1999 Dollars)



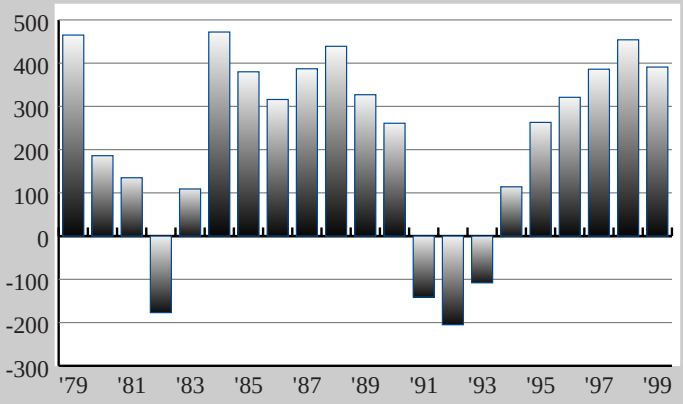
Source: SBE

California Residential Building Permits
(Thousands of Homes)



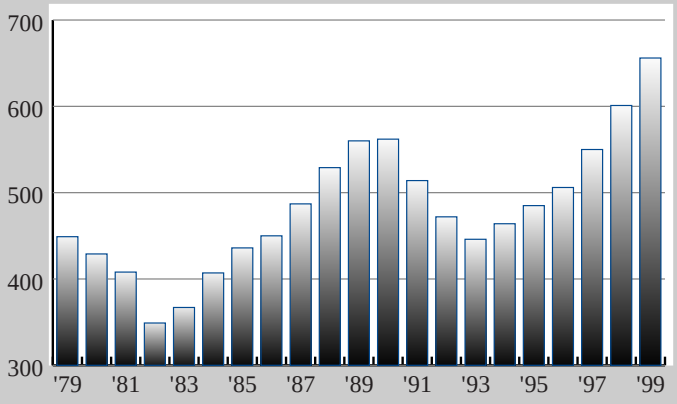
Source: CIRB

Non-farm Jobs Created in California
(Thousands of Jobs)



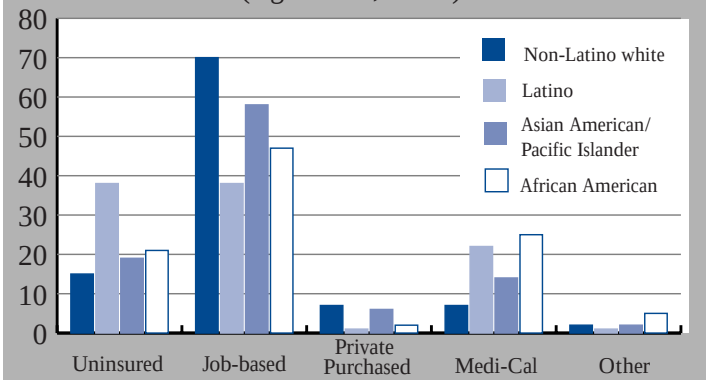
Source: EDD

Construction Jobs Created in California
(Thousands of Jobs)



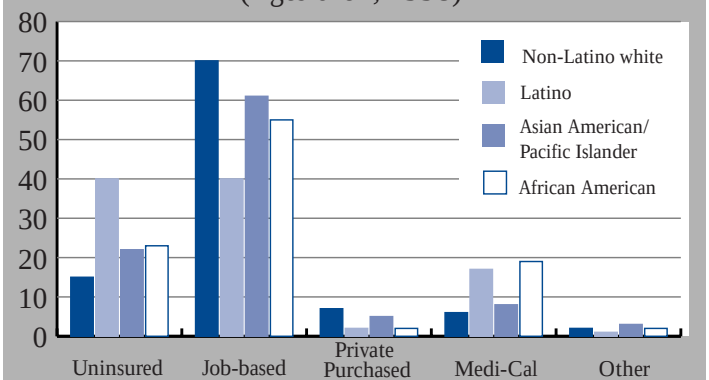
Source: EDD

Health Insurance Coverage by Ethnicity
(Ages 0-64, 1995)



Source: March 1996, Current Population Survey

Health Insurance Coverage by Ethnicity
(Ages 0-64, 1998)



Source: March 1999, Current Population Survey